NEBRASKA DHHS STATE FAIR HEARING FORM

Member Name (*please print*) _____

Member ID Number (*please print*) _____

Member Address (*please print*) _____

_____

I wish to appeal the decision made by Nebraska Total Care on my case because:

_____

_____

Member Signature _____ Date _____

Signature of Authorized Representative

_____ Date _____

Printed Name of Authorized Representative _____

Address of Authorized Representative if different from above

_____

Phone (_____) _____

Social Security Number _____

Name, address and phone number of your Authorized Representative for the Hearing, if any:

_____

_____

Mail the completed form to:

MLTC Appeal Coordinator
PO Box 94967
Lincoln, NE 68509-4967
Fax: (402) 742-1198

The postmark showing the date you mailed your appeal will be the date of your appeal request.

****INCLUDE YOUR *NOTICE OF ADVERSE BENEFIT DETERMINATION* LETTER WITH THIS FORM****